STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056220	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarcrest Nursing Center	5648 East Gotham Street Bell Gardens, CA 90201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct monitoring for one of two sampled residents' (Resident 4) who had behavior of aggressive angry outbursts.This deficient practice had the potential to result in the inaccurate assessment of the effectiveness of Resident 4's medication regimen. Findings:During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 4's diagnoses included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), and hypertension (high blood pressure). During a review of Resident 4's Minimum Data Set (MDS- a resident assessment tool), dated 1/6/2026, the MDS indicated Resident 4's cognitive skills (process of thinking) for daily decision making was moderately impaired. The MDS indicated Resident 4 required moderate assistance (helper does less than half the effort) with toileting, lower body dressing, and personal hygiene. The MDS indicated Resident 4 took antipsychotic medication (medication that affects the mind, emotions, and behavior). During a review of Resident 4's History and Physical (H&P), dated 11/19/2025, the H&P indicated Resident 4 had the capacity to understand and make decisions.During a review of Resident 4's Orders, dated 11/18/2025, the orders indicated to administer quetiapine fumarate (also known as Seroquel, an antipsychotic medication) 100 milligrams (mg, a unit of measurement), by mouth at bedtime for bipolar disorder as evidenced by aggressive angry outbursts. During a review of Resident 4's Care Plan titled, Bipolar Disorder, dated 11/19/2025, the Care Plan indicated to monitor and record occurrences for target behavior symptoms of aggressive angry outbursts. During a review of Resident 4's Initial Psychiatric Evaluation, dated 11/21/2025, the Evaluation's treatment plan indicated to titrate medications (gradually increasing or decreasing a dose of medication to work effectively) according to Resident 4's symptoms.During a concurrent interview and record review on 1/21/2026 at 11:16 a.m., with Registered Nurse (RN) 1, Resident 4's Orders, dated 11/18/2025 through 1/21/2026, were reviewed. The Orders indicated to monitor behaviors of bipolar disorder as manifested by aggressive angry outbursts every shift for the use of quetiapine. The order started on 1/20/2026. RN 1 stated Resident 4 had bipolar disorder and the manifested behavior of aggressive angry outbursts was treated with quetiapine since 11/18/2025. RN 1 stated from 11/18/2025 through 1/19/2026, Resident 4 was not monitored, every shift, for his behavior of aggressive angry outbursts. RN 1 stated the facility was responsible for monitoring the occurrences of Resident 4's behavior to identify the effectiveness of Resident 4's quetiapine treatment. RN 1 stated the facility was responsible for monitoring the trends of increase or decrease in Resident 4's behavior to notify Resident 4's physician. RN 1 stated this information would allow Resident 4's physician to increase or decrease the dose according to Resident 4's behavior occurrences. RN 1 stated without monitoring Resident 4's behavior of (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056220	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarcrest Nursing Center	5648 East Gotham Street Bell Gardens, CA 90201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	aggressive angry outburst, the facility and Resident 4's physician were unaware of the effectiveness of Resident 4's quetiapine treatment and would not allow for the necessary dose adjustments. During an interview on 1/21/2026 at 1:31 p.m., with the Director of Nursing (DON), the DON stated Resident 4 received quetiapine to treat his behavior of aggressive angry outbursts. The DON stated the licensed nurses were responsible for monitoring and documenting the number of behavior occurrences every shift. The DON stated behavior monitoring was necessary to determine whether the quetiapine treatment was effective in treating Resident 4's behavior. The DON stated Resident 4's physician was responsible for reviewing documentation and see any increase or decrease in behaviors to decide whether a Gradual Dose Reduction (GDR- slow lowering of a medication dose while still effectively treating symptoms) was possible. The DON stated without the proper behavior monitoring, the facility was unable to assess Resident 4's condition and placed Resident 4 at risk for worsening behavior and not receiving the proper treatment. During a review of the facility's Policy and Procedure (P&P) titled, Antipsychotic Medication Use, undated, the P&P indicated, The staff will observe, document, and report to the Attending Physician information regarding the effectiveness of any interventions, including antipsychotic medications.During a review of the facility's P&P titled, Behavioral Assessment, Intervention and Monitoring, undated, the P&P indicated when medications were prescribed for behavioral symptoms, documentation would include specific target behaviors and monitoring for efficacy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056220	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarcrest Nursing Center	5648 East Gotham Street Bell Gardens, CA 90201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its policy and procedure (P&P) titled, Resident-to-Resident Altercations which indicated to separate residents after an altercation for two of two sampled residents (Residents 4 and 5).This deficient practice resulted in Resident 4 and 5 being involved in a verbal altercation which escalated to Resident 5 pushing Resident 4 into the nightstand and sustaining an abrasion (scratch) above his right eyebrow. Findings:1. During a review of Resident 4's admission Record (Face Sheet), the admission Record indicated Resident 4 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 4's diagnoses included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and hypertension (high blood pressure). During a review of Resident 4's Minimum Data Set (MDS- a resident assessment tool), dated 1/6/2026, the MDS indicated Resident 4's cognitive skills (process of thinking) for daily decision making was moderately impaired. The MDS indicated Resident 4 required moderate assistance (helper does less than half the effort) with toileting, lower body dressing, and personal hygiene. The MDS indicated Resident 4 took antipsychotic medication (medication that affects the mind, emotions, and behavior). During a review of Resident 4's History and Physical (H&P), dated 11/19/2025, the H&P indicated Resident 4 had the capacity to understand and make decisions.During a review of Resident 4's Change in Condition (COC), dated 1/10/2026, the COC indicated, on 1/10/2026, Resident 4 argued with Resident 5 which escalated to Resident 5 pushing Resident 4 from behind onto the nightstand. The COC indicated Resident 4 sustained an abrasion (scratch) over his right eyebrow. During a review of Resident 4's Skin Assessment, dated 1/10/2026, the Skin Assessment indicated Resident 4 had an abrasion above his right eyebrow which measured 1.5 centimeters (cm, unit of measurement) in length and 1cm in width. During a review of Resident 4's Post- Event Review, dated 1/10/2026, the Post-Event Review indicated Resident 4 asked Resident 5 to keep his cigarettes while Resident 4 was at the general acute care hospital (GACH). The Post-Event Review indicated Residents 4 and 5 had a disagreement when Resident 4 learned Resident 5 smoked his cigarettes. The Post-Event Review indicated Resident 5 told Resident 4 to shut up and shoved Resident 4 into his nightstand.During an interview on 1/21/2026 at 9:31 a.m., with Resident 4, Resident 4 stated he asked Resident 5 to keep three packs of cigarettes while he went to the GACH. Resident 4 stated when he was readmitted to the facility, he found out that Resident 5 smoked all his cigarettes. Resident 4 stated he became angry which resulted in a yelling match between the two of them and began calling Resident 5 derogatory (disrespectful) names. Resident 4 stated Resident 5 was on the other side of his curtain when Resident 5 pushed him against the nightstand. Resident 4 stated he hit his head on the nightstand and had a scratch above his right eyebrow. 2. During a review of Resident 5's admission Record (Face Sheet), the admission Record indicated Resident 5 was admitted to the facility on [DATE] with diagnoses that included osteomyelitis (inflammation of bone or bone marrow, usually due to infection) in the right ankle and foot, type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and acute kidney failure (a sudden, often reversible, loss of kidney function).During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5's cognition was intact. The MDS indicated Resident 5 required moderate assistance with toileting, bathing, and lower body dressing. During a review of Resident 5's H&P, dated 12/10/2025, the H&P indicated Resident 5 had the capacity to understand and make decisions. During a review of Resident 5's COC, dated 1/10/2026, the COC indicated, on 1/10/2026, Resident 5 swore at Resident 4 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056220	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarcrest Nursing Center	5648 East Gotham Street Bell Gardens, CA 90201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and wanted Resident 4 to shut up. The COC indicated Resident 5 pushed Resident 4 against the nightstand. During an interview on 1/21/2026 at 7:35 a.m., with Registered Nurse (RN) 2, RN 2 stated the physical altercation between Residents 4 and 5 occurred before change of shift on 1/10/2026. RN 2 stated when she arrived at 7 a.m. on 1/10/2026, she was informed by RN 3 that Residents 4 and 5 had a verbal altercation on 1/9/2026, and were able to calm down afterwards. RN 2 stated the licensed nurses from the previous shifts felt Residents 4 and 5 were able to come to an agreement about their misunderstanding and left it as that. RN 2 stated Residents 4 and 5 were roommates and left in the same room after their verbal altercation on 1/9/2026. RN 2 stated when any argument occurred between residents, especially if the residents were roommates, a room change should be conducted to prevent another altercation from occurring. RN 2 stated Resident 4 was moved to a different room after the physical altercation on 1/10/2026. During an interview on 1/21/2026 at 9:05 a.m., with RN 3, RN 3 stated she was informed by RN 4 Residents 4 and 5 had a verbal altercation, however, after Residents 4 and 5 calmed down, both residents went back to their bed and fell asleep. RN 3 stated after she received shift change report from RN 4, she went into Residents 4 and 5's room and saw both residents sleeping. RN 3 stated she did not feel a room change was needed during her shift because Residents 4 and 5 calmed down and were both sleeping. RN 3 stated Residents 4 and 5's physical altercation occurred on 1/10/2026 at approximately 6:30 a.m. with Certified Nursing Assistant (CNA) 1 as a witness. RN 3 stated CNA 1 informed her Residents 4 and 5 were arguing and escalated to Resident 5 pushing Resident 4 against the nightstand. RN 3 stated when she entered the room, the altercation between Residents 4 and 5 was over and both residents were separated. RN 3 stated Resident 4 had an abrasion above his right eyebrow. During an interview on 1/21/2026 at 10:01 a.m., with CNA 1, CNA 1 stated, on 1/10/2026, she heard yelling from Residents 4 and 5's room. CNA 1 stated she entered the room and witnessed Resident 5 stand up from his bed and push Resident 4 against the nightstand. CNA 1 stated she called for assistance, separated Residents 4 and 5, and informed RN 3 of the altercation. During an interview on 1/21/2026 at 10:12 p.m., with RN 4, RN 4 stated LVN 2 and LVN 3 informed him, on 1/9/2026 during the 3 p.m. to 11 p.m. shift, Residents 4 and 5 had a verbal altercation. RN 4 stated after he was informed of the verbal altercation, he went to Residents 4 and 5's room and found both residents sleeping. RN 4 stated he did not want to wake either Resident 4 or Resident 5 and informed RN 3 that Resident 4 or Resident 5 should be moved to a different room once they awoke. During an interview on 1/21/2026 at 11:59 a.m., with LVN 2, LVN 2 stated, on 1/9/2026 at approximately 10:30 p.m., LVN 3 asked for her assistance in deescalating a verbal altercation between Residents 4 and 5. LVN 2 stated Resident 4 was angry at Resident 5 because Resident 5 smoked his cigarettes and was still holding onto his phone. LVN 2 stated Resident 5 gave the phone back to Resident 4 and both residents calmed down. LVN 2 stated she told Resident 5, [Resident 4] is upset right now, I know you are trying to help but let him cool off. LVN 2 stated when she and LVN 3 left the room, Residents 4 and 5 were no not arguing anymore and they were fine.During an interview on 1/21/2026 at 12:34 p.m., with LVN 3, LVN 3 stated, on 1/9/2026 at approximately 10 p.m., she was notified that Residents 4 and 5 were engaged in a verbal altercation. LVN 3 stated Resident 4 was upset because he entrusted his cell phone and cigarettes to Resident 5 and wanted his belongings back. LVN 3 stated she and LVN 2 deescalated the situation by returning Resident 4's phone and providing Resident 4 a cigarette until he could acquire more. LVN 3 stated, prior to leaving Residents 4 and 5's room, both residents were not arguing anymore and were left in the room to sleep. During an interview on 1/21/2026 at 12:44 p.m., with the Social Services Director (SSD), the SSD stated she was informed of the verbal and physical altercations between Residents 4 and 5 the following Monday, on 1/12/2026. The SSD stated whenever (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056220	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarcrest Nursing Center	5648 East Gotham Street Bell Gardens, CA 90201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents have a verbal altercation, both residents need to be separated from one another. The SSD stated Residents 4 and 5 were roommates when they had their first verbal altercation. The SSD stated in Residents 4 and 5's situation, a room change should have been conducted to deescalate the situation further and to prevent another altercation from occurring. During an interview on 1/21/2026 at 1:15 p.m., with the Director of Nursing (DON), the DON stated Residents 4 and 5 had a verbal altercation, on 1/9/2026 during the 3 p.m. to 11 p.m. shift, regarding Resident 4's cell phone and cigarettes he entrusted to Resident 5. The DON stated the verbal altercation was a misunderstanding where the licensed nurses de-escalated the situation and came to a resolution. The DON stated Residents 4 and 5 were kept in the same room after the verbal altercation. The DON stated, on 1/10/2026 at 6:30 a.m., Residents 4 and 5 had another verbal altercation about Resident 4's cigarettes which escalated into a physical altercation where Resident 5 pushed Resident 4 against the nightstand. The DON stated a room change for either Resident 4 or Resident 5 should have been an option after their verbal altercation on 1/9/2026 to prevent the second altercation on 1/10/2026. During a concurrent interview and record review on 1/21/2026 at 1:37 p.m., with the Administrator (ADM), the facility's policy and procedure (P&P) titled, Resident-to-Resident Altercations, undated, was reviewed. The P&P indicated if two residents were involved in an altercation, the facility's staff were responsible for separating the residents and institute measures to calm the situation. The ADM stated Residents 4 and 5's disagreement, on 1/9/2026, was considered a verbal altercation. The ADM stated Residents 4 and 5 were roommates and neither of them were moved to a different room after the verbal altercation was de-escalated. The ADM stated because Residents 4 and 5 were not separated and were present in the same room, another verbal altercation, on 1/10/2026, occurred and escalated into a physical altercation. The ADM stated the altercation on 1/10/2026 could have been prevented if a room change was done to separate Residents 4 and 5.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056220	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarcrest Nursing Center	5648 East Gotham Street Bell Gardens, CA 90201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to submit a Preadmission Screening and Resident Review (PASRR- a federally mandated screening process designed to ensure individuals with serious mental illnesses or intellectual/development disabilities receive the necessary support) Level 1 Screening for one of five sampled residents (Resident 4).This deficient practice had the potential to result in Resident 4 not receiving the necessary and appropriate psychiatric level treatment and evaluation in the facility.Findings:During a review of Resident 4's admission Record (Face Sheet), the admission Record indicated Resident 4 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 4's diagnoses included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and hypertension (high blood pressure). During a review of Resident 4's Minimum Data Set (MDS- a resident assessment tool), dated 1/6/2026, the MDS indicated Resident 4's cognitive skills (process of thinking) for daily decision making was moderately impaired. The MDS indicated Resident 4 required moderate assistance (helper does less than half the effort) with toileting, lower body dressing, and personal hygiene. The MDS indicated Resident 4 took antipsychotic medication (medication that affects the mind, emotions, and behavior). During a review of Resident 4's History and Physical (H&P), dated 11/19/2025, the H&P indicated Resident 4 had the capacity to understand and make decisions.During a review of Resident 4's Orders, order date 11/18/2025, the Orders indicated to administer quetiapine fumarate (also known as Seroquel, an antipsychotic medication) 100 milligrams (mg, a unit of measurement), by mouth at bedtime for bipolar disorder as evidenced by aggressive angry outbursts. During a review of Resident 4's Care Plan titled, Bipolar Disorder, dated 11/19/2025, the Care Plan indicated to administer antipsychotic medications as ordered.During a review of Resident 4's Initial Psychiatric Evaluation, dated 11/21/2025, the Evaluation's treatment plan indicated to titrate mediations (gradually increasing or decreasing a dose of medication to work effectively) according to the symptoms, observe for deterioration in function, and provide emotional support for compliance in treatment. During a concurrent interview and record review on 1/21/2026 at 11:02 a.m., with the Minimum Data Set Nurse (MDSN), Resident 4's Preadmission Screening and Resident Review (PASRR- a federally mandated screening process designed to ensure individuals with serious mental illnesses or intellectual/development disabilities receive the necessary support) Level 1 Screening, dated 11/18/2025, was reviewed. The PASRR Level 1 Screening indicated Resident 4 tested positive for a serious mental illness. The MDSN stated prior to admission, every resident had a PASRR Level 1 done to assess for serious mental illness or intellectual/development disabilities. The MDSN stated usually when a resident tested positive in the Level 1 Screening, a more in-depth Level 2 Mental Health Evaluation was supposed to be conducted. During a concurrent interview and record review on 1/21/2026 at 11:33 a.m., with the MDSN, Resident 4's PASRR Level 2 Letter, dated 11/18/2025, was reviewed. The Letter indicated a Level 2 Mental Health Evaluation was not required due to exempted hospital discharge. The Letter indicated, If the individual remains in the [nursing home] longer than 30 days, the facility must resubmit a new Level 1 Screening as a Resident Review on the 31st day. The MDSN stated a Level 2 Mental Health Evaluation was not required when Resident 4 was admitted to the facility due to Resident 4's physician certifying Resident 4's stay in the facility was likely to be less than 30 days. The MDSN stated Resident 4 was admitted to the facility on [DATE], which was more than 30 days ago. The MDSN stated the facility was responsible for submitting a new Resident Review Level 1. The MDSN stated due to the delay in submitting a Resident Review (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056220	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarcrest Nursing Center	5648 East Gotham Street Bell Gardens, CA 90201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Level 1 and the delay in a Level 2 Mental Health Evaluation being conducted, Resident 4 was at risk of not receiving extra mental health services and not being in an appropriate skilled facility to meet his needs. During an interview on 1/21/2026 at 1:28 p.m., with the Director of Nursing (DON), the DON stated PASSR Level 1 Screenings were usually completed prior to the resident's admission to the facility and depending on the result, a Level 2 Mental Health Evaluation followed. The DON stated Resident 4 had an exception and did not require a Level 2 Mental Health Evaluation, however, the facility was responsible for submitting a new Level 1 Screening because of Resident 4's admission lasting longer than 30 days. The DON stated the purpose of completing the Level 1 Screening and subsequent Level 2 Mental Health Evaluation was to assess Resident 4's appropriate skilled placement and to provide any necessary mental health resources. The DON stated without the proper screening and evaluation, Resident 4 was at risk of not receiving the necessary mental health care and treatment. During a review of the facility's policy and procedure (P&P) titled, admission Criteria, revised 3/2019, the P&P indicated, All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-admission Screening and Resident Review (PASARR) process. The facility conducts a Level 1 PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, ID, or RD. The P&P indicated the state may choose not to apply the preadmission screening requirement if the attending physician has certified (prior to admission) that the individual will likely need less than 30 days of care at the facility,During a review of the California Department of Health Services (DHCS- a state agency which manages and oversees health care access) webpage topic, link https://www.dhcs.ca.gov/services/MH/Pages/PASRR_faq_level2.aspx, titled, PASRR Level 2 Screening Process, undated, the webpage indicated, a Level 2 Evaluation was not required if a 30-day Exempted Hospital Discharge was certified by a physician. The webpage indicated, If the individual's stay exceeds 30 calendar days, then the [nursing facility] is required to submit a [Resident Review] Level 1 screening by the 40th calendar after admission.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056220	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarcrest Nursing Center	5648 East Gotham Street Bell Gardens, CA 90201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop a person-centered care plan with interventions for one of three sampled residents' (Resident 1) use of side rails (short rails on one or both sides of the bed that can be used to assist in bed mobility).This deficient practice had the potential to result in Resident 1 not receiving the necessary care to safely utilize the side rails.Cross Reference F700.Findings:During a review of Resident 1's admission Record (Face Sheet), the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included generalized muscle weakness (decrease in muscle strength), dementia (a progressive state of decline in mental abilities), and chronic atrial fibrillation (long-term heart condition where the heart beats quickly and irregularly). The admission Record indicated Resident 1 had a Responsible Party (RP 1).During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 11/2/2025, the MDS indicated Resident 1's cognition (process of thinking) was severely impaired. The MDS indicated Resident 1 was dependent on staff's assistance with toileting, bathing, and lower body dressing. During a review of Resident 1's History and Physical (H&P), dated 6/9/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Orders, active on 1/20/2026, the Orders did not indicate the use of grab bars. During an observation on 1/20/2026 at 8:23 a.m., in Resident 1's room, Resident 1 was observed lying in bed. The bed had bilateral (both sides) grab bars (a type of side rails, which are short rails on one or both sides of the bed that can be used to assist in bed mobility).During a concurrent observation and interview on 1/20/2026 at 1:41 p.m., with Registered Nurse (RN) 1, in Resident 1's room, Resident 1's bed was observed with bilateral grab bars. RN 1 stated the grab bars were used to aid in Resident 1's bed mobility and repositioning. During a concurrent interview and record review on 1/20/2026 at 2 p.m., with Registered Nurse (RN) 1, Resident 1's Care Plans, dated 10/26/2022 through 1/20/2026, were reviewed. Resident 1 did not have a care plan to address her use of grab bars. RN 1 stated Resident 1 had grab bars to aid in bed mobility and repositioning, therefore, should have had a care plan developed to reflect such use. RN 1 stated the care plan would alert the licensed nurses and certified nursing assistants to visually monitor Resident 1 for the proper use of the grab bars and safety while Resident 1 was in bed. RN 1 stated care plans were used as a communication tool to ensure everyone was aware and on the same page. RN 1 stated the care plan was necessary to outline staff's interventions to monitor the condition of the grab bars and to monitor Resident 1 to prevent entrapment (becoming caught, trapped, or tangled in between a small space) and other injuries. RN 1 stated without a care plan to address Resident 1's use of grab bars, Resident 1 was at risk of injury.During an interview on 1/21/2026 at 1:10 p.m., with the Director of Nursing (DON), the DON stated Resident 1 had grab bars to assist in bed mobility and repositioning. The DON stated a care plan should have been developed to indicate the reason for the grab bars and the interventions needed to minimize any safety risks associated with the grab bars. The DON stated the interventions would indicate the necessary monitoring such as Resident 1's position in bed, working condition, and other safety precautions. The DON stated without a care plan, Resident 1 was at risk of not receiving the necessary care to safely utilize the side rails.During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, undated, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056220	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarcrest Nursing Center	5648 East Gotham Street Bell Gardens, CA 90201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to conduct a side rail utilization assessment prior to installing side rails, obtain an order for the use of side rails, and ensure informed consent was obtained prior to the use of side rails for two of three sampled residents (Residents 1 and 2).These deficient practices had the potential for the unsafe use of Resident 1 and 2's side rails which could lead to entrapment (becoming caught, trapped, or tangled in between a small space) and injury. Findings:1. During a review of Resident 1's admission Record (Face Sheet), the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included generalized muscle weakness (decrease in muscle strength), dementia (a progressive state of decline in mental abilities), and chronic atrial fibrillation (long-term heart condition where the heart beats quickly and irregularly). The admission Record indicated Resident 1 had a Responsible Party (RP 1).During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 11/2/2025, the MDS indicated Resident 1's cognition (process of thinking) was severely impaired. The MDS indicated Resident 1 was dependent on staff's assistance with toileting, bathing, and lower body dressing. During a review of Resident 1's History and Physical (H&P), dated 6/9/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During an observation on 1/20/2026 at 8:23 a.m., in Resident 1's room, Resident 1 was observed lying in bed. The bed had bilateral (both sides) grab bars (a type of side rails, which are short rails on one or both sides of the bed that can be used to assist in bed mobility).During a concurrent observation and interview on 1/20/2026 at 1:41 p.m., with Registered Nurse (RN) 1, in Resident 1's room, Resident 1's bed was observed with bilateral grab bars. RN 1 stated the grab bars were used to aid in Resident 1's bed mobility and repositioning. During a concurrent interview and record review on 1/20/2026 at 1:48 p.m., with RN 1, Resident 1's Side Rail Utilization Assessment, dated 11/2/2025, was reviewed. The Assessment indicated Resident 1 did not have side rails currently in use or requested. RN 1 stated she did not know the date Resident 1's grab bars were installed. RN 1 stated an accurate Side Rail Utilization Assessment should have been completed to ensure Resident 1 was safe and able to use the grab bars for mobility and repositioning. RN 1 stated Resident 1's cognition was impaired and could intermittently (occurs irregularly) follow commands. RN 1 stated assessing Resident 1's safety was essential in preventing falls, entrapment (becoming caught, trapped, or tangled in between a small space), and injury.During a concurrent interview and record review on 1/20/2026 at 1:51 p.m., with RN 1, Resident 1's Orders, active on 1/20/2026, were reviewed. The Orders did not indicate an order for bilateral grab bars. RN 1 stated an order was necessary to inform Resident 1's physician of the need for grab bars and to allow Resident 1's physician to determine whether installing the grab bars was safe. RN 1 stated grab bars had the potential to be used as a restraint (device or material used to intentionally limit an individual's freedom of movement) and a physician's order was necessary to distinguish the actual use of the grab bars. During a concurrent interview and record review on 1/20/2026 at 1:57 p.m., with RN 1, Resident 1's electric health record (eHR), dated 1/20/2026, the eHR did not indicate informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) was obtained and verified for Resident 1's use of grab bars. RN 1 stated prior to installing grab bars to the bed, RP 1 had to be notified of the reason for use, the risks, and the benefits and to allow RP 1 to make an informed (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056220	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarcrest Nursing Center	5648 East Gotham Street Bell Gardens, CA 90201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	decision whether the grab bars could be used. RN 1 stated there was no documentation of RP 1's informed consent to install grab bars to Resident 1's bed. 2. During a review of Resident 2's admission Record (Face Sheet), the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 2's diagnoses included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke- caused by a blocked blood vessel in the brain) affecting the left side, lack of coordination (inability to move the body in a controlled way), and weakness.During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognition was moderately impaired. The MDS indicated Resident 2 was dependent on staff's assistance with toileting, bathing, and lower body dressing. During a review of Resident 2's H&P, dated 6/25/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. The H&P indicated RP 2 was Resident 2's surrogate decisionmaker (trusted person who makes healthcare choices for someone who could no longer make them for themselves).During an observation on 1/20/2026 at 10:38 a.m., in Resident 2's room, Resident 2 was observed lying in bed. The bed had bilateral grab bars.During a concurrent observation and interview on 1/20/2026 at 1:42 p.m., with RN 1, in Resident 2's room, Resident 2 was observed lying in bed. The bed had bilateral grab bars. RN 1 stated Resident 2 used the grab bars to aid in repositioning.During a concurrent interview and record review on 1/20/2026 at 1:50 p.m., with RN 1, Resident 2's Side Rail Utilization Assessment, dated 1/14/2026, was reviewed. The Assessment indicated Resident 2 did not have side rails currently in use or requested. RN 1 stated she did not know the date Resident 2's grab bars were installed. RN 1 stated an accurate Side Rail Utilization Assessment should have been completed to ensure Resident 2 was safe and able to use the grab bars for mobility and repositioning. During a concurrent interview and record review on 1/20/2026 at 1:55 p.m., with RN 1, Resident 2's Orders, active on 1/20/2026, were reviewed. The Orders did not indicate an order for bilateral grab bars. RN 1 stated Resident 2 did not have an order to use bilateral grab bars for mobility and repositioning. RN 1 stated an order was necessary to inform Resident 2's physician of the need for the grab bars and to allow Resident 2's physician to determine whether installing the grab bars was safe. During a concurrent interview and record review on 1/20/2026 at 1:58 p.m., with RN 1, Resident 2's eHR, dated 1/20/2026, the eHR did not indicate informed consent was obtained and verified for Resident 2's use of grab bars. RN 1 stated prior to installing grab bars, Resident 2 and RP 2 had to be notified of the reason for use, the risks, and the benefits and allow Resident 2 and RP 2 to make an informed decision whether the grab bars could be used. RN 1 stated there was no documentation of informed consent verification to install grab bars to Resident 2's bed.During an interview on 1/20/2026 at 1:10 p.m., with the Director of Nursing (DON), the DON stated prior to installing side rails to Resident 1 and 2's bed, the facility was to obtain an order from the resident's physician, conduct a side rail utilization assessment, and verify informed consent was obtained. The DON stated a physician's order was necessary to ensure the physician agreed installing side rails were appropriate and safe for Resident 1 and 2. The DON stated the side rail utilization assessment was necessary to indicate other interventions done prior to utilizing the side rails to assist in justifying the need for the side rails. The DON stated verifying informed consent was obtained was important to ensure Resident 1, Resident 2, RP 1, and RP 2 were aware of the safety risks associated with the use of side rails. The DON stated all three were part of the facility's process to ensure Resident 1 and 2 were safe to have side rails installed on their bed. The DON stated by not following the facility's process, Residents 1 and 2 were at risk of entrapment and injury. During a review of the facility's Policy and Procedure (P&P) titled, Bed Safety and Bed Rails, undated, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056220	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarcrest Nursing Center	5648 East Gotham Street Bell Gardens, CA 90201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the P&P indicated, Consideration is given to the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment. Bed frames, mattresses and bed rails are checked for compatibility and size prior to use. The P&P indicated, Additional safety measures are implemented for residents who have been identified as having a higher than usual risk for injury including bed entrapment. The P&P indicated, The resident assessment to determine risk of entrapment includes, but is not limited to:a. medical diagnosis, conditions, symptoms, and/or behavioral symptoms;b. size and weight;c. sleep habits;d. medication(s);e. acute medical or surgical interventions;f. underlying medical conditions;g. existence of delirium;h. ability to toilet self safely;i. cognition;j. communication;k. mobility (in and out of bed); andl. risk of falling.The P&P indicated, Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent. The following information will be included in the consent:a. The assessed medical needs that will be addressed with the use of bed rails;b. The resident's risks from the use of bed rails and how these will be mitigated;c. The alternatives that were attempted but failed to [NAME] the resident's needs; andd. The alternatives that were considered but not attempted and the reasons.